

Ethical conflicts in the context of the COVID-19 pandemic

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ABSTRACT

Background: Healthcare setups in India are encountering a lot of medical, ethical, legal, and social challenges endorsed by the ongoing COVID-19 crisis, modifying the healthcare protocols, which are considered a standard of care. The ethical conflicts are pressurizing the decision-makers of society, to revamp the basic principles and traditional assumptions of our present healthcare modalities.

Objectives: This report addresses the common but crucial ethical issues, encountered by healthcare workers e.g., doctors and paramedics in day-to-day healthcare practice during the COVID-19 pandemic.

Materials and methods: This report tries to cover several ethical aspects of COVID-19 such as: setting priority of screening; professional responsibility of healthcare workers; dilemma encountered by a doctor; compromise of patient confidentiality; allocation of scanty resources; end-of-life situation, and certain critical clinical scenarios.

Results and conclusion: COVID warriors from the health sector possess dual responsibilities of taking utmost care of COVID patients ethically, along with self-protection from this havoc. COVID-19 has taught us the lesson that, extra-ordinary time calls for extra-ordinary measures. Also, intervention performed upon the patient affects not only the patient, but also the whole of society.

Introduction

COVID-19 is an infectious disease, that spreads more robustly than our health-service systems can tackle. As global communities try to combat the COVID crisis, lots of critical ethical, legal, and social crossroads have evolved. These ethical conflicts are pressurizing the decision-makers of society, to revamp the basic principles of our present healthcare modalities.¹ Enumerating the relevant aspects, as follows:

1. Portion of the population, ideally to be screened for COVID-19, in limited availability of tests:

Screening tests create a conflict ethically, due to the scanty number of tests, and are with suboptimal specificity and sensitivity. On a priority basis, symptomatic patients should be tested first because early diagnosis, and prompt interventions are critical, as most of the spread is from this said fraction of the population. As the improvement of tests in quantity and quality, gets available, the screening of asymptomatic healthcare workers can also be performed.^{1,2}

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2. Professional responsibility of healthcare workers, in the management of highly contagious COVID-19:

Appropriate personal protective equipment (PPE) does a commendable job in the prevention of exposure, thereby restricting the spread of infection. But many healthcare organizations fail to accommodate a sufficient quantity of PPE for adequate protection of their staff, altering dynamics ethically. A certain fraction of populations such as the elderly, and healthcare workers with underlying comorbidities are more susceptible to the deleterious effects of COVID-19. They are vulnerable while dealing with COVID-19 patients, with insufficient PPE. With the surplus availability of PPE, it becomes an ethical duty of clinicians to give care to COVID-19 victims. New guidelines and Standard Operating Procedures (SOPs) can be formulated and implied. The health workers must be trained in the standard guidelines of universal precautions e.g., Personal Protective Equipment (PPE) use.^{3,4}

3. Addressing the compromise of patient confidentiality in reporting the positive cases to the public and the higher authority concerned:

Securing COVID-19-positive patients' privacy is an ethical conflict as it possesses a potential threat to society. Currently, prejudicial stigma is not linked with testing positive for COVID. So, breakage of the seal of confidentiality is not so challenging and framing decisions on public interest is ethically less conflicting. Healthcare centers should be advised to warn their healthcare workers of the positive status of COVID-19 patients. The COVID-19 patients who agree to disclose their current health status to those contacts, which they might have put at risk, should have the opportunity of informing for tracing purposes. With the high contagiousness of COVID-19, confidentiality must be restricted for sake of mass public health. So, the conventional rule of 'Professional Secrecy' can be superseded by 'Privileged communication' in this

critical scenario. It is quite pivotal that, hospitals and physicians should convey to the concerned public agencies regarding COVID positive cases, thereby fetching more data to be tabulated, analyzed, and finally processed to frame management guidelines.^{4,5}

4. Rational allocation of limited resources such as ventilators, ICU beds, as well as life-saving remedies:

Much more attention is being paid to the allocation of scanty resources wisely in this current pandemic. Various guidelines are now available to different healthcare facilities. Discrete opinions should be framed regarding the allocation of limited lifesaving modalities on a priority basis or the triage. Collaborative support for conserving scarce resources is a mandate in this crisis.¹⁰

5. Ideal protocol to be followed in the tragic 'End-of-Life' situation:

In such of tragic 'end-of-life' (EOL) situation, the ICU core members should not debar the family members from the golden chance of conveying the last goodbye to the patient. Visitations, may it be physical or virtual, should be made possible. The concerned family members should be prepared mentally beforehand for the impending tragic bereavement. Also, EOL-family conferences may be arranged remotely if possible and if required. Honest counseling and conversations are vital for the family members to get prepared for the saddest news of the death of their nearest and dearest ones. It is required to overcome anxiety, and withstand depression, PTSD, and complicated grief afterward.^{7,8}

6. Ethical crossroads in certain critical scenarios:

6.1 HIV-positive patients:

HIV-positive patients may be more susceptible to getting extremely ill with COVID. They should implement 'COVID-appropriate behavior' (vaccination, regular mask-wearing,



Figure 1 Spectrum of dilemmas encountered by treating doctor during management of COVID-19.^{1,9}

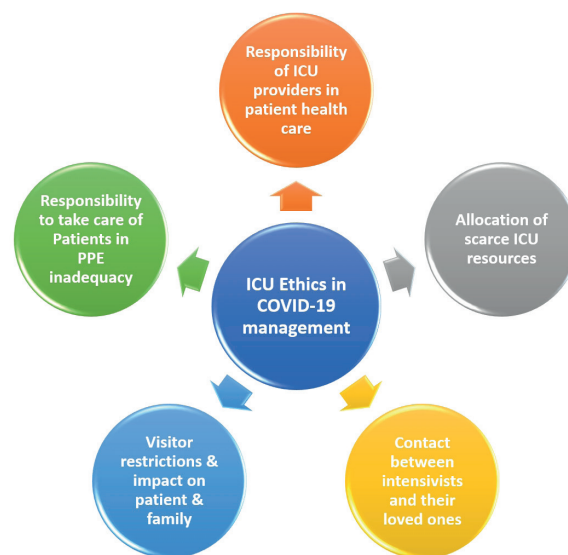


Figure 2 Various ethical loopholes in critical care of COVID-19 victims in intensive care unit of hospital.^{7,8}

and practicing social distancing, exercise, and yoga) at the earliest. Despite being fully vaccinated, persons with comorbidity or immune suppressants might not be protected. They should not discontinue taking all precautions, ideally suggested for unvaccinated persons, unless advised medically.^{5,9}

6.2 Pregnancy:

Pregnancy involves certain physiological changes, which increase vulnerability to catching respiratory viruses like COVID-19. These alterations in the body might last long, even after childbirth. Breast milk, according to current evidence, is unlikely to pass the virus to babies. Nevertheless, COVID-appropriate behavior is to have stringently adhered to. Preventive COVID vaccine is universally advised for all individuals aged 12 and above, as well as, those who are pregnant, breastfeeding, or attempting to conceive. Precautionary measures like washing hands for 20 seconds with soap and water, before breastfeeding or expressing breast milk, along with using a hand sanitizer containing at least 60% alcohol in the unavailability of soap and water. It is recommended by the precautionary guidelines for COVID-19 set by World Health Organization (WHO) and Center for Disease Control (CDC).^{3,4}

Conclusion

The COVID-19 crisis is robustly remodeling our benchmarks of priorities, may it be medical, ethical, legal, or social. But, some of our ethical obligations remain unaltered. Undoubtedly, our commitment to advocacy, transparency, and empathy for human life remains unchanged. COVID-19 has taught us the lesson that, any intervention that is performed upon the patient affects not only the patient but also the whole of society.^{9,10}

Conflicts of Interest

The authors declare no conflict of interest

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References

- [1] White DB, Lo B. A framework for rationing ventilators and critical care beds during the COVID-19 pandemic. *JAMA*. 2020; 323(18): 1773-4. doi: 10.1001/jama.2020.5046.
- [2] Maves RC, Downar J, Dichter JR, Hick JL, Devereaux A, Geiling JA, Kissoon N, Hupert N, Niven AS, King MA, Robinson LL. Triage of scarce critical care resources in COVID-19 an implementation guide for regional allocation: an expert panel report of the task force for mass critical care and the American College of Chest Physicians. *Chest*. 2020; 158(1): 212-25. doi: 10.1016/j.chest.2020.03.063.
- [3] Emanuel EJ, Persad G, Upshur R, Thome B, Parker M, Glickman A, Zhang C, Boyle C, Smith M, Phillips JP. Fair allocation of scarce medical resources in the time of COVID-19. *New England Journal of Medicine*. 2020; 382(21): 2049-55. doi: 10.1056/NEJMs2005114.
- [4] Morganstein JC. Annals for Hospitalists Inpatient Notes-Preparing for Battle: How Hospitalists Can Manage the Stress of COVID-19. *Annals of internal medicine*. 2020; 172(10): HO2-3. doi: 10.7326/M20-1897
- [5] Papadimos TJ, Marcolini EG, Hadian M, Hardart GE, Ward N, Levy MM, Stawicki SP, Davidson JE. Ethics of outbreaks position statement. Part 1: Therapies, treatment limitations, and duty to treat. *Critical care medicine*. 2018; 46(11): 1842-55. doi: 10.1097/CCM.0000000000003416.
- [6] Biddison EL, Gwon HS, Schoch-Spana M, Regenber AC, Juliano C, Faden RR, Toner ES. Scarce resource allocation during disasters: a mixed-method community engagement study. *Chest*. 2018; 153(1): 187-95. doi: 10.1016/j.chest.2017.08.001.
- [7] Laurent A, Bonnet M, Capellier G, Aslanian P, Hebert P. Emotional impact of end-of-life decisions on professional relationships in the ICU: an obstacle to collegiality?. *Critical care medicine*. 2017; 45(12): 2023-30. doi: 10.1097/CCM.0000000000002710.
- [8] Rawal G, Yadav S, Kumar R. Post-intensive care syndrome: an overview. *Journal of translational internal medicine*. 2017; 5(2): 90-2. doi: 10.1515/jtim-2016-0016.
- [9] Bansal P, Bingemann TA, Greenhawt M, Mosnaim G, Nanda A, Oppenheimer J, Sharma H, Stukus D, Shaker M. Clinician wellness during the COVID-19 pandemic: extraordinary times and unusual challenges for the allergist/immunologist. *The Journal of Allergy and Clinical Immunology: In Practice*. 2020; 8(6): 1781-90. doi: 10.1016/j.jaip.2020.04.001.
- [10] Vergano M, Bertolini G, Giannini A, Gristina GR, Livigni S, Mistraretti G, Riccioni L, Petrini F. Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances: the Italian perspective during the COVID-19 epidemic. *Critical Care*. 2020; 24(1): 1-3. doi: 10.1186/s13054-020-02891-w.